

5174

CERTIFICATE OF DEATH

05169

Reg. Dist. No. 185-

| | | | | | | | |
|---|-------------------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DEGRACE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 709 MARKET ST. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First EMMA Middle BROADWATER Last BAKER | | | 4. DATE OF DEATH Month MAY Day 6 Year 1956 | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 8, 1885 | | 9. AGE (In years lost birthday) 70 yrs. | IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) HAVRE DE GRACE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME SUMMERFIELD WILSON | | | 14. MOTHER'S MAIDEN NAME CYNTHIA JANE CONNELLY | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. James C. Carroll Chicago, ILL. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiac 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease Hypertension DUE TO (c) Chronic Alcoholism | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a. 9 p. m. Month 19 Day 19 Year 19 | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 1954 to May 6, 1956 that I last saw the deceased alive on May 6, 1956 , and that death occurred at 9 a.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles J. Foley M.D. | | | ADDRESS (Street, city or town, state) 4008 Murray Ave. Baltimore, Md. DATE SIGNED 5/7/56 | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF MAY 10, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM. | | 22d. LOCATION (City, town, or county) (State) HAVRE DEGRACE, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell | | | ADDRESS Havre Grace, Md. | | 24a. REC'D BY REGISTRAR A. L. Lewis M.D. | | 24b. REGISTRAR'S SIGNATURE |

TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the signature of the attending physician and completely filled in by the funeral director, or the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5188

CERTIFICATE OF DEATH

Reg. Dist. No.

05170
180

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon | | | | c. LENGTH OF STAY IN 1b 15 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Grady Middle P. Last Blackburn | | | | 4. DATE OF DEATH Month May Day 25 Year 19 56 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 22, 1915 | | 9. AGE (In years lost birthday) 41 yrs. | 10. IF UNDER 1 YEAR Months 1 Days 7 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt., | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Philllips | | | | 14. MOTHER'S MAIDEN NAME Ida Maines | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-16-0411 | | 17. INFORMANT Tracy W. Blackburn Address Abingdon Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 25, 1956 , to May 25, 1956 , that I last saw the deceased alive on May 25, 1956 , and that death occurred at 3:25 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 5-27-56 ACTUAL SIGNATURE William A. Tyson M.D. PHYSICIAN'S NAME (Type) William A. Tyson Kingsville Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 29, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Grove | | 22d. LOCATION (City, town, or county) (State) Bel Air, R.D. Harford Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son Howard K. McComas Jr. | | | | ADDRESS Abingdon Md. | | 24a. REC'D BY REGISTRAR May 28, 1956 DATE 24b. REGISTRAR'S SIGNATURE Norma B. Moore | |

MAY 29 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5175

CERTIFICATE OF DEATH

05172

Reg. Dist. No. 182

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------------------|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARTFORD</u> | | STATE <u>MD</u> COUNTY <u>HARTFORD</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN <u>BEL AIR MD</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | STREET ADDRESS (If rural give location) | | ADDRESS <u>218 FRANKLIN ST</u> | |
| TOWN <u>BEL AIR MD</u> | | <u>Life</u> | | STREET ADDRESS | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>ANNIE E LOX</u> | | | | <u>May 14 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| <u>F</u> | <u>Col</u> | <u>Widow</u> | <u>Jan 18 - 1877</u> | <u>79</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Housewife</u> | | <u>BEL AIR MD</u> | | <u>US</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Isaac Lue</u> | | | | <u>Adela Spencer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | <u>✓</u> | | <u>Pauline Lue BEL AIR MD</u> <u>218 FRANKLIN ST</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| <u>443X IMMEDIATE CAUSE (A) <u>CARDIO-RESP FAILURE</u></u> | | | | | | | <u>24 HOURS</u> |
| <u>ANTECEDENT CAUSE(S) DUE TO (B) <u>APOPLEXY</u></u> | | | | | | | <u>36 HOURS</u> |
| <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u></u> | | | | | | | <u>4 YEARS</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>JAN 1954</u> to <u>MAY 1956</u>, that I last saw the deceased alive on <u>13 MAY 1956</u>, and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>H. A. Adair</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>BEL AIR MD</u> | | DATE SIGNED <u>14 May 56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>May 16/56</u> | | <u>AGBURY</u> | | <u>Churchville Rural MD</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>DATE 5-14-56</u> | | <u>Phyllis Lowood</u> | | <u>Geo T Foster</u> | | <u>BEL AIR MD</u> | |

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE WHERE DEATH OCCURRED

PLACE OF BIRTH

MARYLAND

COUNTY OF

CITY OF

DATE OF BIRTH

PLACE OF BIRTH

CITY OF

COUNTY OF

STATE OF

DATE OF DEATH

PLACE OF DEATH

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STATE OF

BUREAU V. 2

MAY 16 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5176

CERTIFICATE OF DEATH

05173-185-

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace | | | |
| c. LENGTH OF STAY IN 1b 6 yrs | | | | d. STREET ADDRESS 462 Bourbon Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Delores Middle Josephine Last Cullum | | | | 4. DATE OF DEATH Month May Day 31 Year 19 56 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/31/32 | |
| 9. AGE (In years last birthday) 23 22 yrs. | | IF UNDER 1 YEAR Months 23 Days 22 Hours 22 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler | | 10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Dewey Cuffley | | 14. MOTHER'S MAIDEN NAME Clara Rosenberger | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 216-28-8844 | | 17. INFORMANT Address Nelson Cullum Havre de Grace, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerulo nephritis DUE TO (c) Pericarditis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week 2 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pericarditis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 5/24/56 to 5/31/56 , that I last saw the deceased alive on 5/31/56 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. | | | | | | | |
| 21a. ACTUAL SIGNATURE Howard H. Wachsmann M.D. | | | | 21b. ADDRESS (Street, city or town, state) Havre de Grace Md | | | |
| 21c. PHYSICIAN'S NAME (Type) Irvin L. Wachsmann | | | | 21d. DATE SIGNED 5/31/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 4, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Calvary Methodist | | 22d. LOCATION (City, town, or county) (State) Bel Air, R.D. Harford Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Wachsmann & Son | | | | ADDRESS Abingdon Md. | | 24a. REC'D BY REGISTRAR June 4-56 | |
| 24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D. | | | | DATE June 4-56 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-------------------|--|---------------|--|-------------|--|-------------------|--|--------------------|--|-----------------|--|-------------------|--|-----------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | | Cause of Death | | Manner of Death | |
| John Doe | | 45 | | Male | | White | | June 10, 1956 | | Home | | Heart Disease | | Natural | |
| Residence | | Occupation | | Education | | Marital Status | | Previous Illnesses | | Medical History | | Physician's Name | | Hospital Name | |
| 123 Main St | | Teacher | | High School | | Married | | Hypertension | | None | | Dr. Smith | | St. Mary's | |
| Burial Place | | Burial Date | | Burial Time | | Burial Place | | Burial Date | | Burial Time | | Burial Place | | Burial Date | |
| Catholic Cemetery | | June 12, 1956 | | 10:00 AM | | Catholic Cemetery | | June 12, 1956 | | 10:00 AM | | Catholic Cemetery | | June 12, 1956 | |

46-58-8845

| | | | | | | | | | | | | | | | |
|-------------------|--|---------------|--|-------------|--|-------------------|--|--------------------|--|-----------------|--|-------------------|--|-----------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | | Cause of Death | | Manner of Death | |
| John Doe | | 45 | | Male | | White | | June 10, 1956 | | Home | | Heart Disease | | Natural | |
| Residence | | Occupation | | Education | | Marital Status | | Previous Illnesses | | Medical History | | Physician's Name | | Hospital Name | |
| 123 Main St | | Teacher | | High School | | Married | | Hypertension | | None | | Dr. Smith | | St. Mary's | |
| Burial Place | | Burial Date | | Burial Time | | Burial Place | | Burial Date | | Burial Time | | Burial Place | | Burial Date | |
| Catholic Cemetery | | June 12, 1956 | | 10:00 AM | | Catholic Cemetery | | June 12, 1956 | | 10:00 AM | | Catholic Cemetery | | June 12, 1956 | |

RECEIVED
JUN 6 1956
BUREAU V. S.

05174

5189 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH

COUNTY Harford

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN PerrymanLENGTH OF STAY
(in this place)
18 yrsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN PerrymanSTREET ADDRESS
(If rural give location)3. NAME OF DECEASED
(Type or Print)

(First)

(Middle)

(Last)

JOHN

F

DALTON, SR

4. DATE OF DEATH

(Month)

(Day)

(Year)

May, 25, 1956

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED,
(Specify)

divorced

8. DATE OF BIRTH

Dec. 20 1900

9. AGE last birthday

55 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman

10b. KIND OF BUSINESS OR INDUSTRY
Wholesale Fish

11. BIRTHPLACE (State or foreign country)

Belcamp, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

/Frank Dalton

14. MOTHER'S MAIDEN NAME

Catherine Gillease

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

?

17. INFORMANT & ADDRESS

John F. Dalton, Jr., Joppa Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

18. MEDICAL CERTIFICATION

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

Instant

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at 9:00 A.M. from the causes and on the date stated above.

SIGNATURE

Philip W. Heuman

ADDRESS (Street, city, town, state)

DATE SIGNED

Deputy County Coroner, Harford County, Md.

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

May 28, 1956

St. Francis

Abingdon, Harford, Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE May 28-56

Nellie G. Perry

Howard K. McComas & Son Abingdon, Md.

INSTRUCTIONS: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form No. 10-56

AT USUAL RESIDENCE (HOUSE OR APARTMENT)

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

DATE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

CAUSE OF DEATH
 IMEDIATE CAUSE
 UNDERLYING CAUSE

CAUSE OF DEATH
 IMEDIATE CAUSE
 UNDERLYING CAUSE

PLACE OF DEATH
 NAME OF PHYSICIAN
 SIGNATURE OF PHYSICIAN

PLACE OF DEATH
 NAME OF PHYSICIAN
 SIGNATURE OF PHYSICIAN

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 NAME OF PHYSICIAN
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PLACE OF DEATH
 NAME OF PHYSICIAN
 SIGNATURE OF PHYSICIAN

PLACE OF DEATH
 NAME OF PHYSICIAN
 SIGNATURE OF PHYSICIAN

RECEIVED

RECEIVED

BUREAU V. S.

MAY 31 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5190

CERTIFICATE OF DEATH

05175

Reg. Dist. No. 782

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Rural</u> <u>Bel Air</u> | | <u>1 1/2 yrs.</u> | | TOWN <u>Rural</u> <u>Bel Air</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescing Home</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Francis A. DeBow</u> | | | | <u>May 10, 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>F</u> | <u>W</u> | <u>Widow</u> | <u>Sept. 26, 1882</u> | <u>73 yrs.</u> | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>retired housewife</u> | | | | <u>Harford County Md</u> | | <u>U.S.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>James O. Grafton</u> | | | | <u>Matilda Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>none</u> | | <u>Kirk DeBow, Bel Air, Maryland</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (A) <u>331x Massive Cerebral Hemorrhage</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>and Hypertension</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>March</u>, 19<u>35</u>, to <u>May 10</u>, 19<u>56</u>, that I last saw the deceased alive on <u>May 9</u>, 19<u>56</u>, and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Hudson</u> | | | | ADDRESS (Street, city, town, state) <u>Forest Hill</u> | | DATE SIGNED <u>May 5/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <u>Burial</u> | | <u>May 12/56</u> | | <u>Mt Tabor</u> | | <u>Bel Air, Harford Co Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>5-11-56</u> | | <u>Priscilla Lowndes</u> | | <u>Joseph T. Jones</u> | | <u>Bel Air Md</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

5177

Reg. Dist. No.

181

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

NEW YORK STATE DEPARTMENT OF HEALTH—BUREAU OF

BUREAU V. S.

MAY 23 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05177

5191

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|---|-----------------|--|----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Harford</u> | |
| CITY OR TOWN <u>Fallston</u> | | LENGTH OF STAY (In this place) <u>66 yrs</u> | | CITY OR TOWN <u>Fallston Rural</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Clifton</u> | | (Middle) <u>L O K E R</u> | | (Last) <u>Durham</u> | | (Month) <u>May</u> (Day) <u>10</u> (Year) <u>19 56</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Feb 12 1890</u> | 9. AGE last birthday <u>66</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | | Months <u>2</u> | Days <u>20</u> | Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pleasantville MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Durham</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Loker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT & ADDRESS <u>Pearl Durham Fallston Md.</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 163X IMMEDIATE CAUSE (A) <u>Malignant adenomatosis of lung.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 22 mos</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>March 1955</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Malignant adenomatosis of lung.</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb. 23, 1955</u> , to <u>May 10, 1956</u> , that I last saw the deceased alive on <u>May 10, 1956</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Robert Barthel</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u> | | DATE SIGNED <u>5-11-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>May 12-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Friendship</u> | | LOCATION (City, town, or county) (State) <u>Fallston Harford Md.</u> | |
| 24. REC'D BY REGISTRAR <u>5-14-56</u> | | REGISTRAR'S SIGNATURE <u>Purcella Lowndes</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Knight</u> | | ADDRESS <u>Pleasantville Md.</u> | |

CERTIFICATE OF DEATH

A. MANNER OF DEATH: (Check one)

1. Natural Causes
 2. Accident
 3. Suicide
 4. Homicide
 5. Unknown

6. Other (Specify):

7. Date of Death:

8. Place of Death:

9. Name of Physician:

10. Name of Hospital:

11. Name of Coroner:

12. Name of Registrar:

13. Name of Burial Place:

14. Name of Undertaker:

15. Name of Funeral Home:

16. Name of Cemetery:

17. Name of Interment:

18. Name of Decedent:

19. Age:

20. Sex:

21. Race:

22. Occupation:

23. Education:

24. Marital Status:

25. Date of Birth:

26. Date of Death:

27. Date of Burial:

28. Date of Interment:

29. Date of Registration:

30. Name of Physician:

31. Name of Hospital:

32. Name of Coroner:

33. Name of Registrar:

34. Name of Burial Place:

35. Name of Undertaker:

36. Name of Funeral Home:

37. Name of Cemetery:

38. Name of Interment:

39. Name of Registration:

40. Name of Decedent:

41. Age:

42. Sex:

43. Race:

44. Occupation:

45. Education:

46. Marital Status:

47. Date of Birth:

48. Date of Death:

49. Date of Burial:

50. Date of Interment:

51. Date of Registration:

52. Name of Decedent:

53. Age:

54. Sex:

55. Race:

56. Occupation:

57. Education:

58. Marital Status:

59. Date of Birth:

60. Date of Death:

61. Date of Burial:

62. Date of Interment:

63. Date of Registration:

64. Name of Decedent:

65. Age:

RECEIVED

BUREAU V. S.

MAY 16 1936

RECEIVED

5178

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | |
|---|---------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air - Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | d. STREET ADDRESS <u>R.D.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Percy</u> Last <u>HARWAY</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR 8 1873</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>8</u> Days <u>3</u> Hours <u>1</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD -</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>BENJAMIN FRANKLIN HARWAY</u> | | 14. MOTHER'S MAIDEN NAME <u>HANNAH JANE FORWOOD</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>MRS. MARION V. HARWAY</u> | | Address <u>BELAIR P.D.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Coronary thrombosis with myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>Gangrene of both lower extremities</u> INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>1 week</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 19th, 1956</u> , to <u>May 1st, 1956</u> , that I last saw the deceased alive on <u>May 1st, 1956</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u> | | ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harre de Grace, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u> | | DATE SIGNED <u>5/1/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>MAY 4, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>CALVERY CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>HARFORD Co. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. MADISON MITCHELL</u> | | ADDRESS <u>MD. HARRE DE GRACE</u> | |
| 24a. REC'D BY REGISTRAR <u>May 4-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05179

5192

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Rt. 1, Bel Air</u> | | | | TOWN <u>Rt. 1, Bel Air</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>James H. Howell</u> | | | | <u>May 22 1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u> | | 8. DATE OF BIRTH <u>Jan 7 1890</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE last birthday <u>66</u> yrs. | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| <u>Crop Farmer</u> | | <u>Farmer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Delaware</u> | | | |
| 13. FATHER'S NAME <u>John L. Howell</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mrs. M. C. Gentry</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>017-12-6827</u> | | 17. INFORMANT & ADDRESS <u>Mrs. James H. Howell</u> | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 162x IMMEDIATE CAUSE (A) <u>Bronchogenic Carcinoma Lung (left)</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>March 2</u> , 19 <u>56</u> , to <u>May 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 22</u> , 19 <u>56</u> , and that death occurred at <u>4:15p</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Hudson</u> | | | | ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> | | DATE SIGNED <u>5-24-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>May 25, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Welcoming Home</u> | | LOCATION (City, town, or county) (State) <u>Harford Co Md</u> | |
| 24. REC'D BY REGISTRAR <u>May 24, 1956</u> | | REGISTRAR'S SIGNATURE <u>C. W. Kirk</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u> | | ADDRESS <u>Washington Md.</u> | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text]
2. SEX: [Faint text]
3. AGE: [Faint text]
4. DATE OF BIRTH: [Faint text]
5. PLACE OF BIRTH: [Faint text]
6. OCCUPATION: [Faint text]
7. CAUSE OF DEATH: [Faint text]
8. PLACE OF DEATH: [Faint text]
9. DATE OF DEATH: [Faint text]
10. SIGNATURE OF PHYSICIAN: [Faint text]
11. SIGNATURE OF REGISTRAR: [Faint text]

NOTIFICATION

BUREAU V. P.

MAY 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5193 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05180

Reg. Dist. No. 180

| | | | | | | | |
|--|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAGNOLIA</u> | | c. LENGTH OF STAY IN 1b <u>LIFE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FT HOYLE RD.</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) <u>NORMAN</u> First <u>(NMT)</u> Middle <u>JEFFERS</u> Last | | | | 4. DATE OF DEATH Month <u>May</u> , Day <u>31</u> , Year <u>19 56</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV 7, 1913</u> | 9. AGE (In years last birthday) <u>42</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARINE</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | |
| 13. FATHER'S NAME <u>James Jeffers</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lena Guttermuth</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>717-07-5685</u> | | 17. INFORMANT Address <u>ELWOOD CRAWFORD JEFFERS, SAME</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUFFOCATION FROM SMOKE</u> <u>916.0</u> DUE TO <u>FILLED ROOM WHILE</u> Conditions, if any, which gave rise to immediate cause (b) <u>ASLEEP.</u> (c), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>BEDDING AND MATTRESS CAUGHT FIRE IN SLEEP</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>MAY 31 19 56</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u> | | | |
| 20f. (City or town) <u>MAGNOLIA</u> | | (County) <u>HARFORD</u> | | (State) <u>MD</u> | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Philip W. Harrison</u> | | | | DATE SIGNED <u>May 31, 1956</u> | | | |
| EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 2, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u> | | | |
| 22d. LOCATION (City, town, or county) <u>Abingdon Harford</u> | | (State) <u>Md.</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u> | | | | 24a. REC'D BY REGISTRAR <u>June 2, 1956</u> | | | |
| ADDRESS <u>Abingdon Md.</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Norma G. Moore</u> | | | |

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any further information is necessary, please enclose a separate statement, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--|-------------------------|--|----------------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | |
| JAMES A. HARRIS | | 45 | | M | | W | | JAN 15 1936 | |
| PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | LOCALITY | |
| CHICAGO, ILL. | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | CHICAGO, ILL. | |
| OCCUPATION | | EDUCATION | | RELIGION | | MARITAL STATUS | | SINGLE | |
| CLERK | | HIGH SCHOOL | | METHODIST | | MARRIED | | MARRIED | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | |
| NONE | | NONE | | NONE | | NONE | | NONE | |
| SIGNS AND SYMPTOMS | | POST MORTEM FINDINGS | | LABORATORY EXAMINATIONS | | TOXICOLOGICAL EXAMINATIONS | | OTHER EXAMINATIONS | |
| PAIN IN CHEST, SHORTNESS OF BREATH, SWELLING OF FEET | | HEART ENLARGED, CORONARY ARTERIES SCLEROTIC | | NONE | | NONE | | NONE | |
| FAMILY HISTORY | | SOCIAL HISTORY | | HISTORICAL DATA | | PATHOLOGICAL DATA | | MICROSCOPIC DATA | |
| NONE | | NONE | | NONE | | NONE | | NONE | |
| CERTIFICATE OF DEATH | | SIGNATURE OF EXAMINER | | DATE | | PLACE | | LOCALITY | |
| JAMES A. HARRIS | | JAMES A. HARRIS | | JAN 15 1936 | | CHICAGO, ILL. | | CHICAGO, ILL. | |

BUREAU V. 2

5 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5194 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05181

Reg. Dist. No. 181

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|--|--|--|--|--------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Army Chem. Center, Edgewood</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Army Chem. Center, Edgewood, Maryland</u> d. STREET ADDRESS <u>Apt. 108B, Grant Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>JOHNSON, Jr.</u> First <u>C.</u> Middle <u>Eugene</u> Last <u>Johnson, Jr.</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>19 56</u> | | | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>21 Oct. 1925</u> | | 9. AGE (In years last birthday) <u>30</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Billeting Officer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Northbrook, W. Virginia</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | |
| 13. FATHER'S NAME <u>Eugene C. Johnson Jr.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>not given</u> | | | | 17. INFORMANT Address <u>Center</u> <u>Current Tour 24 Aug 51 to 14 May 56/Mr. Shelbert, Chf Ofer, Psnl-Army Chem.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds, multiple.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Homicide</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>4:30 P.M. May 14 56</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> | | | | 20f. (City or town) <u>Edgewood</u> | | (County) <u>Harford</u> | | (State) <u>Md.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Bruce D Fallis Capt MC</u> M.D. | | | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) <u>BRUCE D. FALLIS, Captain, M.C.</u> | | | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 17 May 1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | | | 22b. DATE THEREOF <u>May 17th 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY | | | | 22d. LOCATION (City, town, or county) <u>Princeton West Virginia</u> | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Farruig Aberdeen Md</u> | | | | | | ADDRESS | | 24a. REC'D BY REGISTRAR | | | | 24b. REGISTRAR'S SIGNATURE <u>Mellie E Perry</u> | | | | | |

MEDICAL CERTIFICATION

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 21 1956

BUREAU V. S.

5179

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 Haure de Grace</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u> | | d. STREET ADDRESS <u>800 Fountain st.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOYNER</u> | | 4. DATE OF DEATH Month Day Year <u>MAY 1 19 56</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>COLORED</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr: 130, 1956</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>—</u> | | 14. MOTHER'S MAIDEN NAME <u>Gertrude Joyner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT Address | |

| | | |
|---|---|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>4/30</u> , 1956, to <u>5/1</u> , 1956, that I last saw the deceased alive on <u>5/1</u> , 1956, and that death occurred at <u>12:25</u> M, from the causes and on the date stated above. | | |
| ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D. <u>809 Revolution St., Haure de Grace, Md.</u> | | DATE SIGNED <u>5/2/56</u> |
| PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>5-1-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u> |
| 22d. LOCATION (City, town, or county) (State) <u>Haure de Grace Md.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Tully</u> administrator | | 24a. REC'D BY REGISTRAR DATE <u>May 6 1956</u> |
| | | 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u> |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--------------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. DATE OF BIRTH | | 6. PLACE OF DEATH | |
| 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | |
| 10. MEDICAL HISTORY | | 11. PRESENT ILLNESS | | 12. TREATMENT | |
| 13. HISTORY OF PRESENT ILLNESS | | 14. PHYSICIAN'S SIGNATURE | | 15. DATE | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF WITNESSES | | 18. SIGNATURE OF CLERK | |
| 19. SIGNATURE OF MINISTER OF THE GOSPEL | | 20. SIGNATURE OF CHURCH CLERK | | 21. SIGNATURE OF CORONER | |
| 22. SIGNATURE OF JURY | | 23. SIGNATURE OF JUDGE | | 24. SIGNATURE OF SHERIFF | |
| 25. SIGNATURE OF DISTRICT ATTORNEY | | 26. SIGNATURE OF COUNTY CLERK | | 27. SIGNATURE OF TOWNSHIP CLERK | |
| 28. SIGNATURE OF VILLAGE CLERK | | 29. SIGNATURE OF POSTMASTER | | 30. SIGNATURE OF SCHOOL CLERK | |
| 31. SIGNATURE OF CHURCH CLERK | | 32. SIGNATURE OF CHURCH CLERK | | 33. SIGNATURE OF CHURCH CLERK | |
| 34. SIGNATURE OF CHURCH CLERK | | 35. SIGNATURE OF CHURCH CLERK | | 36. SIGNATURE OF CHURCH CLERK | |
| 37. SIGNATURE OF CHURCH CLERK | | 38. SIGNATURE OF CHURCH CLERK | | 39. SIGNATURE OF CHURCH CLERK | |
| 40. SIGNATURE OF CHURCH CLERK | | 41. SIGNATURE OF CHURCH CLERK | | 42. SIGNATURE OF CHURCH CLERK | |
| 43. SIGNATURE OF CHURCH CLERK | | 44. SIGNATURE OF CHURCH CLERK | | 45. SIGNATURE OF CHURCH CLERK | |
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| 52. SIGNATURE OF CHURCH CLERK | | 53. SIGNATURE OF CHURCH CLERK | | 54. SIGNATURE OF CHURCH CLERK | |
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| 61. SIGNATURE OF CHURCH CLERK | | 62. SIGNATURE OF CHURCH CLERK | | 63. SIGNATURE OF CHURCH CLERK | |
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| 88. SIGNATURE OF CHURCH CLERK | | 89. SIGNATURE OF CHURCH CLERK | | 90. SIGNATURE OF CHURCH CLERK | |
| 91. SIGNATURE OF CHURCH CLERK | | 92. SIGNATURE OF CHURCH CLERK | | 93. SIGNATURE OF CHURCH CLERK | |
| 94. SIGNATURE OF CHURCH CLERK | | 95. SIGNATURE OF CHURCH CLERK | | 96. SIGNATURE OF CHURCH CLERK | |
| 97. SIGNATURE OF CHURCH CLERK | | 98. SIGNATURE OF CHURCH CLERK | | 99. SIGNATURE OF CHURCH CLERK | |
| 100. SIGNATURE OF CHURCH CLERK | | 101. SIGNATURE OF CHURCH CLERK | | 102. SIGNATURE OF CHURCH CLERK | |

RECEIVED
MAY 7 1956
BUREAU V. B.

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05183

5180

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | | | | | |
|--|------------------|--|-----------------------|---|-----------------|--|-------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Harford</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Harford</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <i>Harve De Grace</i> | | | | TOWN <i>Harve De Grace</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hospital #221 Seneca Ave</i> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <i>William D. Kelley</i> | | | | <i>May 29 1956</i> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <i>Male</i> | <i>White</i> | | <i>10 August 1920</i> | <i>35</i> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Heavy Equip.</i> | | <i>U.S. Gov't.</i> | | <i>South Carolina</i> | | <i>U.S.A.</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>Operator Billy Kelley</i> | | | | <i>Minnie Hopkins</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| <i>yes World war 2</i> | | | | | | <i>Md. 221 Seneca St. Havre de Grace</i> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <i>Coronary Thrombosis</i> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| <i>Cardiovascular Hypertension</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| <i>Disease</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Thurs</i> , 19 <i>36</i> , to <i>Thurs</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>May 29</i> , 19 <i>56</i> , and that death occurred at <i>8:15 P.</i> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Charles J. Foley M.D.</i> | | | | ADDRESS (Street, city, town, state) <i>Havre de Grace Md</i> | | | |
| | | | | DATE SIGNED <i>5/29/56</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>1 June 1956</i> | | <i>Oak Grove</i> | | <i>RD. Bel Air, Md.</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <i>June 2-1956</i> | | <i>G. L. Lewis m. d.</i> | | <i>John E. Varring Aberdeen Md</i> | | | |

CERTIFICATE OF DEATH

Page 1 of 1

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Signature of witness

13. Signature of funeral director

14. Signature of undertaker

15. Signature of cemetery

16. Signature of burial place

17. Signature of interment

18. Signature of final disposition

19. Signature of final resting place

20. Signature of final burial place

21. Signature of final interment

22. Signature of final disposition

23. Signature of final resting place

24. Signature of final burial place

25. Signature of final interment

26. Signature of final disposition

27. Signature of final resting place

28. Signature of final burial place

29. Signature of final interment

30. Signature of final disposition

BUREAU V. 3

1956 B

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5195

CERTIFICATE OF DEATH

05184

Reg. Dist. No. 181

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital | | d. STREET ADDRESS — | |
| 3. NAME OF DECEASED (Type or print) First Infant Middle LINDSAY Last LINDSAY | | 4. DATE OF DEATH Month May Day 19 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 19 1956 |
| 9. AGE (In years last birthday) yrs. 5 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Stewart Lindsay | | 14. MOTHER'S MAIDEN NAME Evelyn Jean Braddy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Father/19B Hartman St, Edgewood, Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital-fetal and placental abnormalities 159.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) abnormalities DUE TO (c) abnormalities | | INTERVAL BETWEEN ONSET AND DEATH — | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 19 , 19 56 , to May 19 , 19 56 , that I last saw the deceased alive on May 19 , 19 56 , and that death occurred at 1:31p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED May 19/56 | | | |
| ACTUAL SIGNATURE Alan C Lakin M.D. | | 21b. PHYSICIAN'S NAME (Type) ALAN C LAKIN, Capt, MC | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/22/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Post Cemetery | | 22d. LOCATION (City, town, or county) (State) Army Chemical Center, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Herring ADDRESS Aberdeen, Md. | | 24a. REC'D BY REGISTRAR May 22-56 | |
| 24b. REGISTRAR'S SIGNATURE Nellie G. Perry | | | |

2050202XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5196

CERTIFICATE OF DEATH

05185

Reg. Dist. No. 182

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HILL</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HILL</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>P.</u> Last <u>LINKOUS</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1956</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-17-1894</u> | 9. AGE (In years last birthday) <u>62</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>W^m W. LINKOUS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SARAH SPARKS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>235-30-9804</u> | | 17. INFORMANT <u>Walter W Linkous Forest Hill Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral vascular collapse, terminating</u> <u>5020</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. hypertensive cardio-vascular disease</u> DUE TO <u>Chr. bronchitis</u> (c) <u>Chr. Emphysema & Chr. Bronchial asthma</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 1954</u> , 19 <u>54</u> , to <u>May 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 5, 1956</u> , 19 <u>56</u> , and that death occurred at <u>3:55 PM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Willard P. Hudson</u> | | ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> | | | | DATE SIGNED <u>5-5-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M. D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-7-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FELLOWSHIP</u> | | 22d. LOCATION (City, town, or county) (State) <u>PLESVILLE HARFORD Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Hill - Forest Hill Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-6-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

MAY 8 1951

RECEIVED

5181

CERTIFICATE OF DEATH

Reg. Dist. No. 180

| | | | | | | | |
|---|--|-------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Havre de Grace</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>99 Harford Memorial</u> | | | | d. STREET ADDRESS <u>Stephney Area.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Stevenson</u> Middle <u>Wm.</u> Last <u>Lofline</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>19th</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3/3/1894</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | 10. UNDER 1 YEAR | | 11. IF UNDER 24 HRS. | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.F.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rural Mail Carrier</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal Dept.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.F.</u> | | | |
| 13. FATHER'S NAME <u>Edgar P. Lofline</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lora E. Tick.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>214-34-3539</u> | | | |
| 17. INFORMANT <u>Harry C. Lofline, Aberdeen P.O. Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Chronic Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis Cordis</u> (c) <u>Vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>3-14</u> , 19 <u>49</u> , to <u>5-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-20</u> , 19 <u>56</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Havre de Grace, Md 5-22-8</u> DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | | | 22. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel cemetery</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>5/22/56</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel cemetery</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Harford Co. Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garrison</u> | | | | 24a. REC'D BY REGISTRAR <u>May 22-56</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u> | | | | 24c. DATE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 24 1956

BUREAU V. S.

VS. A15ME(5)
5M 9/55

TO DE **MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any de necessary, please exe
cute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
or removal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05187

Reg. Dist. No. 182

| | | | | | | | |
|--|------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u> | | c. LENGTH OF STAY IN 1b <u>42 hr.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>Anderson</u> Last <u>McCombs</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>055, 1881</u> | | 9. AGE (In years last birthday) <u>74</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John A Anderson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nellie Dietz Kar</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Charles McCombs, Bel Air Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>3:1X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH - |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald e Palmer</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>Gerald e. Palmer M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5/12/56 | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>May 15/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Presbyterian</u> | | 22d. LOCATION (City, town, or county) (State) <u>MADONNA Harford Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster, Bel Air, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 5-14-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Pucilla forward</u> | |

MEDICAL CERTIFICATION

2

MAY 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05188/51

5198

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> | | | | c. LENGTH OF STAY IN 1b <u>10 DAYS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US ARMY HOSP(2151-1) APG, Md.</u> | | | | d. STREET ADDRESS <u>302-E Augusta</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Scott</u> First <u>ALAN</u> Middle <u>MOORE</u> Last | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>CAUCASIAN</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAY 20, 1956</u> | |
| 9. AGE (In years lost birthday) yrs. <u>10</u> | | IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Charles I. Moore</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mae E. Mapes</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>FATHER</u> | | Address <u>(as in 2)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>193x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>long nephron nephrosis</u> DUE TO (c) <u>neuroblastoma</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>one hour.</u> <u>4 days.</u> <u>11 days.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>20 May</u> , 1956, to <u>30 May</u> , 1956, that I last saw the deceased alive on <u>30 May</u> , 1956, and that death occurred at <u>0930 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert G. Salasin</u> | | | | ADDRESS (Street, city or town, state) <u>US ARMY HOSPITAL</u> | | DATE SIGNED <u>30 May 56</u> | |
| PHYSICIAN'S NAME (Type) <u>ROBERT G. SALASIN</u> | | | | ADDRESS <u>ABERDEEN PROVING GROUND Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 1st 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Aberdeen Proving Ground Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Herring</u> | | | | ADDRESS <u>Aberdeen, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>June 1-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Willie J. Perry</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

JUN 4 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5182

CERTIFICATE OF DEATH

05189

Reg. Dist. No. 185-

| | | | | | | | |
|--|---|--|------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Cecil</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Harrode Grace</u> | | <u>2 days</u> | | TOWN <u>Rising Sun</u> | | <u>07X-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hosp.</u> | | | | STREET ADDRESS (If rural give location) <u>MAIN ST.</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Baby Girl Nelson</u> | | | | <u>5 20 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>W</u> | <u>NEWBORN</u> | <u>5/18/56</u> | <u>5</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | <u>MD.</u> | | | |
| 13. FATHER'S NAME <u>Dayton Breece Nelson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jenna Mae De Board</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 17. INFORMANT & ADDRESS | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 7620 IMMEDIATE CAUSE (A) <u>Pulmonary atelectasis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hemorrhage in tensoriumbitatorum</u> | | | | <u>2 days</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hyaline membrane disease</u> | | | | <u>2 days</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21i. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>5/18</u> , 19 <u>56</u> , to <u>5/20</u> , 19 <u>56</u> that I last saw the deceased alive on <u>5/20</u> , 19 <u>56</u> , and that death occurred at <u>9:55</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Neil Sanford</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>5/20/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | (State) | |
| <u>Burial</u> | <u>5/22/56</u> | <u>Brookview Cemetery</u> | | <u>Rising Sun, Md.</u> | | | |
| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u> | | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed</u> | | ADDRESS <u>Rising Sun, Md.</u> | |
| DATE <u>May 24-56</u> | | | | | | | |

2071682XV4

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text] 3. AGE: [Faint text] 4. DATE OF BIRTH: [Faint text]

5. PLACE OF BIRTH: [Faint text] 6. OCCUPATION: [Faint text]

7. CAUSE OF DEATH: [Faint text]

8. MEDICAL HISTORY: [Faint text]

9. MEDICAL CERTIFICATION: [Faint text]

10. SIGNATURE OF DECEASED: [Faint text]

11. SIGNATURE OF WITNESSES: [Faint text]

12. SIGNATURE OF PHYSICIAN: [Faint text]

13. SIGNATURE OF REGISTRAR: [Faint text]

14. SIGNATURE OF CLERK: [Faint text]

15. SIGNATURE OF JURY: [Faint text]

16. SIGNATURE OF JUDGE: [Faint text]

17. SIGNATURE OF SHERIFF: [Faint text]

BUREAU V. B.

MAY 25 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 182

5199

| | | | | | | | |
|--|------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Pylesville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD | | | |
| c. LENGTH OF STAY IN 1b 12 HRS. | | | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last NEWCOMB | | | | 4. DATE OF DEATH Month MAY Day 10 Year 1956 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 26, 1896 | | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY Co. HIGHWAY DEPT | | 11. BIRTHPLACE (State or foreign country) HARFORD Co., MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS NEWCOMB | | | | 14. MOTHER'S MAIDEN NAME KATE HARRY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No | | 16. SOCIAL SECURITY NO. 217-14-1498 | | 17. INFORMANT JOHN R. NEWCOMB, EDGEWOOD, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C-V Disease DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1952 to May 10, 1956 , that I last saw the deceased alive on May 9, 1956 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delta, Pa. DATE SIGNED 5/10/56 | | | | | | | |
| ACTUAL SIGNATURE Josiah A. Hunt M.D. | | | | DATE SIGNED 5/10/56 | | | |
| PHYSICIAN'S NAME (Type) Josiah A. Hunt, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5-12-56 | | 22c. NAME OF CEMETERY OR CREMATORY HIGHLAND | | 22d. LOCATION (City, town, or county) (State) STREET, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John H. Harbison | | | | ADDRESS Delta, Pa. | | 24a. REC'D BY REGISTRAR DATE 5-12-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Priscilla Lowork | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

BUREAU V. S.

MAY 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5200 CERTIFICATE OF DEATH

05191
181

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | | | c. LENGTH OF STAY IN 1b 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md | | | | d. STREET ADDRESS 403E Watervliet St | | | |
| 3. NAME OF DECEASED (Type or print) "A" Infant | | | | 4. DATE OF DEATH Month May Day 12 Year 19 56 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 10 1956 | |
| | | | | 9. AGE (In years last birthday) yrs. 2 | | IF UNDER 1 YEAR: Months 2 Days 2 Hours 2 Min. 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Rayford E Nugent | | | | 14. MOTHER'S MAIDEN NAME Shirley E Spires | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Father (as in 2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 Atelectasis left lower lung DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____ DUE TO _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from May 10 , 19 56 , to May 12 , 19 56 , that I last saw the deceased alive on May 12 , 19 56 , and that death occurred at 8:30 a.m. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert D Hume | | | | ADDRESS (Street, city or town, state) DATE SIGNED May 12 1956 | | | |
| PHYSICIAN'S NAME (Type) ROBERT D HUME JR Major MC/US Army Hospital Aberdeen Proving Ground, Md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 16 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Post Cemetery | | 22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John E. Harring | | | | ADDRESS Aberdeen, Maryland | | 24a. REC'D BY REGISTRAR DATE May 16 56 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Willie R Perry | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05192

5201

CERTIFICATE OF DEATH

Reg. Dist. No.

181

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md | | d. STREET ADDRESS 403E Watervliet St | |
| 3. NAME OF DECEASED (Type or print) "B" Infant | | 4. DATE OF DEATH Month May Day 14 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 10 1956 |
| 9. AGE (In years last birthday) yrs. 4 | | IF UNDER 1 YEAR Months 4 Days 14 IF UNDER 24 HRS. Hours 19 Min. 56 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Rayford E Nugent | | 14. MOTHER'S MAIDEN NAME Shirley E Spires | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Father | | Address (as in 2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Pregnancy (Twins) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 10 , 19 56 , to May 14 , 19 56 , that I last saw the deceased alive on May 14 , 19 56 , and that death occurred at 12:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED May 14 1956 | | | |
| ACTUAL SIGNATURE Robert D Hume Jr. M.D. | | PHYSICIAN'S NAME (Type) ROBERT D HUME JR Major MC US Army Hospital Aberdeen Proving Ground, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 16 - 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Post Cemetery | | 22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John E. Farring ADDRESS Aberdeen, Maryland | | 24a. REC'D BY REGISTRAR May 15 - 56 24b. REGISTRAR'S SIGNATURE Tellie R. Fry | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2R50222XVII

5202
Items 8,9: film G198 6-12-56L CERTIFICATE OF DEATH

Reg. Dist. No. 186

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Hande Lane</i> 9 yrs. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Hande Lane Md</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chapel Road</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY <i>Baltimore</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Hande Lane Md</i> d. STREET ADDRESS <i>Chapel Road</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Mel</i> First <i>J.</i> Middle <i>Patone</i> Last | | 4. DATE OF DEATH Month <i>5</i> Day <i>25</i> Year <i>1956</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OF RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9/8/1913</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Shoeing</i> | |
| 11. BIRTH PLACE (State or foreign country) <i>New York</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Ralph Patone</i> | | 14. MOTHER'S MAIDEN NAME <i>Stella Deola</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | |
| 17. INFORMANT <i>Mr. Elmer B. Patone</i> Address <i>Hande Lane Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>June 1950</i> to <i>May 25, 1956</i> , that I last saw the deceased alive on <i>May 25, 1956</i> , and that death occurred at <i>3:30 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>E. J. Simon</i> M.D. | | ADDRESS (Street, city or town, state) <i>Hande Lane</i> DATE SIGNED <i>5-25-56</i> | |
| PHYSICIAN'S NAME (Type) <i>E. J. Simon</i> | | | |
| 22a. DATE OF CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <i>Burial</i> | <i>5/28/56</i> | <i>Angel Hill</i> | <i>Hande Lane, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Simon</i> ADDRESS <i>Hande Lane, Md.</i> | | 24a. REC'D BY REGISTRAR DATE <i>May 26 56</i> | 24b. REGISTRAR'S SIGNATURE <i>G. L. Lewis Md</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

CERTIFICATE OF DEATH

05194

Reg. Dist. No. 182

5183

| | | | | | | | |
|--|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u> | | LENGTH OF STAY (in this place) <u>4 weeks</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u> | | <u>3401-4</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u> | | | | STREET ADDRESS (If rural give location) <u>2509 Hamilton Avenue</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Dominic J. Pechulis</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 5 1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>August 15, 1882</u> | 9. AGE last birthday <u>73</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taylor</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Lithuania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u> |
| 13. FATHER'S NAME <u>Roland Pechulis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>214-26-9515A</u> | | 17. INFORMANT & ADDRESS <u>William Pechulis (Same as above).</u> | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u> | | | | | | <u>Sudden</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypertensive Cardio-</u> | | | | | | <u>Death</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular Disease</u> | | | | | | <u>?</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 21, 1956</u> to <u>May 5, 1956</u> , that I last saw the deceased alive on <u>May 3, 1956</u> , and that death occurred at <u>4:40</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>William P. Hudson</u> | | M.D. <u>Forest Hill Md</u> | | DATE SIGNED <u>5/5/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE HEREOF <u>5/8/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | | LOCATION (City, town, or county) <u>Belair Rd. Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>Miss Priscilla Lowndes</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. W. Kachavskas</u> | | ADDRESS <u>703 McHenry St, Md.</u> | |

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | |
| 10. PLACE OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| 13. SIGNATURE OF WITNESSES | | 14. SIGNATURE OF FUNERAL HOME | | 15. SIGNATURE OF BURIAL PLACE | |

RECEIVED
MAY 9 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05195

5203

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | |
|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Norrisville</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Norrisville</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fawn Grove RD, Penna.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Jossie</u> Middle <u>Maude</u> Last <u>Price</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1956</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 28, 1887</u> | 9. AGE (In years last birthday) <u>69</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>John St. John</u> | | | 14. MOTHER'S MAIDEN NAME <u>Jane Thomas</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-22-9963</u> | 17. INFORMANT <u>Mrs. Mary Callaway</u> Address <u>Fawn Grove Rd, Penna.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (right sided)</u> DUE TO <u>Remedial due to hypertension &</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>arterio-sclerosis, chr. myocarditis.</u> DUE TO (c) <u>arterio-sclerosis, chr. myocarditis.</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>May 3, 1956</u> , to <u>May 16, 1956</u> , that I last saw the deceased alive on <u>May 15, 1956</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Norman H. Gemmill</u> | | M.D. <u>Stewartstown, Pa.</u> | | DATE SIGNED <u>5/16/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill</u> | | <u>Stewartstown, Pa.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5-19-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Glade Spring, Virginia</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Orshum</u> | | ADDRESS <u>Stewartstown Pa</u> | | 24a. REC'D BY REGISTRAR <u>5-18-56</u> | 24b. REGISTRAR'S SIGNATURE <u>Russella Lowwood</u> |

1
after death: Page 4
The law requires that the death certificate be executed within 72 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF DEATH <i>May 21, 1956</i> | | 5. TIME OF DEATH <i>10:30 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Myocardial Infarction</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| 10. OCCUPATION <i>Engineer</i> | | 11. EDUCATION <i>High School</i> | | 12. RELIGION <i>Catholic</i> | |
| 13. MARITAL STATUS <i>Married</i> | | 14. NUMBER OF SPOUSE <i>1</i> | | 15. NUMBER OF CHILDREN <i>2</i> | |
| 16. SIGNATURE OF DECEASED <i>John Doe</i> | | 17. SIGNATURE OF WITNESS <i>John Doe</i> | | 18. SIGNATURE OF PHYSICIAN <i>John Doe</i> | |
| 19. SIGNATURE OF CORONER <i>John Doe</i> | | 20. SIGNATURE OF JURY <i>John Doe</i> | | 21. SIGNATURE OF JUDGE <i>John Doe</i> | |
| 22. SIGNATURE OF CLERK <i>John Doe</i> | | 23. SIGNATURE OF REGISTRAR <i>John Doe</i> | | 24. SIGNATURE OF ARCHIVIST <i>John Doe</i> | |

RECEIVED
MAY 21 1956
BUREAU V. S.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5184
CERTIFICATE OF DEATH

05196

Reg. Dist. No. 182

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air | | c. LENGTH OF STAY IN 1b 2 wks., | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air | | d. STREET ADDRESS 32 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle C. Last Purcell | | 4. DATE OF DEATH Month May Day 11 Year 19 56 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 23, 1878 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Cripps | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT Mrs. Mary Nutall, | | Address Bel Air Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial failure due to DUE TO (c) Brucellar fibrillation - nodal rhythm | | INTERVAL BETWEEN ONSET AND DEATH Instant unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 4, 1956 to May 11, 1956 that I last saw the deceased alive on May 10, 1956 , and that death occurred at 3:50 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Philip W. Heuman M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED Bel Air Harford Co., Maryland | |
| PHYSICIAN'S NAME (Type) Philip W. Heuman | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF May 11, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Grant Runyon, F.H., | 22d. LOCATION (City, town, or county) (State) Easton, North Hampton Pa. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs & Son | | ADDRESS Abingdon Md. | |
| 24a. REC'D BY REGISTRAR DATE 5-12-56 | | 24b. REGISTRAR'S SIGNATURE Priscilla Lownd | |

RECEIVED

MAY 15 1956

BUREAU V. 1

| MAYLAND STATE DEPARTMENT OF HEALTH - BIRTH - DEATH | |
|--|--|
| CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED | |
| 2. SEX | |
| 3. AGE | |
| 4. DATE OF BIRTH | |
| 5. PLACE OF BIRTH | |
| 6. OCCUPATION | |
| 7. CAUSE OF DEATH | |
| 8. PLACE OF DEATH | |
| 9. TIME OF DEATH | |
| 10. SIGNATURE OF PHYSICIAN | |
| 11. SIGNATURE OF REGISTRAR | |
| 12. SIGNATURE OF WITNESSES | |
| 13. SIGNATURE OF DECEASED | |
| 14. SIGNATURE OF NEXT OF KIN | |
| 15. SIGNATURE OF BURIAL OFFICIAL | |
| 16. SIGNATURE OF CHURCH OFFICIAL | |
| 17. SIGNATURE OF FUNERAL HOME | |
| 18. SIGNATURE OF CEMETERY | |
| 19. SIGNATURE OF OTHER | |
| 20. SIGNATURE OF OTHER | |
| 21. SIGNATURE OF OTHER | |
| 22. SIGNATURE OF OTHER | |
| 23. SIGNATURE OF OTHER | |
| 24. SIGNATURE OF OTHER | |
| 25. SIGNATURE OF OTHER | |
| 26. SIGNATURE OF OTHER | |
| 27. SIGNATURE OF OTHER | |
| 28. SIGNATURE OF OTHER | |
| 29. SIGNATURE OF OTHER | |
| 30. SIGNATURE OF OTHER | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5185
CERTIFICATE OF DEATH

05197

Reg. Dist. No.

| | | | | | | | |
|---|--|---------------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CECIL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> | | | | c. LENGTH OF STAY IN 1b <u>6 HRS.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRYVILLE</u> | | | |
| | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) <u>Angelo D. Rapposelli</u> | | | | 4. DATE OF DEATH <u>May 18 1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Apr. 1-1878</u> | |
| | | | | 9. AGE (In years lost birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| | | | | | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWt.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | |
| 13. FATHER'S NAME <u>Clement Dolimpio</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Edith Lepenna</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mrs. Yola Motarscole Perryville, Md.</u> | | | |
| | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cardio Vascular</u> DUE TO <u>Disease Myocarditis</u> (c) <u>Heart Myocarditis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 18</u> , 19 <u>56</u> , to <u>May 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>56</u> , and that death occurred at <u>12:53</u> A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Haver de Grace Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u> | | | | DATE SIGNED <u>5/18/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 21, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. ERIK</u> | | 22d. LOCATION (City, town, or county) (State) <u>Haver de Grace Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u> | | | | ADDRESS <u>Perryville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u> | |
| | | | | DATE <u>May 20-56</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH - BAYVIEW

MAY 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05198
 Reg. Dist. No. 180

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> c. LENGTH OF STAY IN 1b <u>-</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>-</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Orlando</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orlando</u> 48X-3 ✓ d. STREET ADDRESS <u>232 N. Orange Blossom Trail</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>F.</u> Last <u>Reilly</u> 4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u> | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 8, 1904</u> 9. AGE (In years last birthday) <u>51</u> 48 yrs. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u> 11. BIRTHPLACE (State or foreign country) <u>Uniontown, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John Reilly</u> 14. MOTHER'S MAIDEN NAME <u>Pauline Greene</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>209-09-7897</u> 17. INFORMANT <u>Anna Reilly,</u> Address <u>Springdale, Pa.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture both bones L Leg compound</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-pedestrian type</u> 20c. TIME OF INJURY Month, Day, Year <u>5/13/56</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u> 20f. (City or town) <u>Edgewood</u> (County) <u>Harford</u> (State) <u>MD.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/13/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 22b. DATE THEREOF <u>May 15, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Kuznicki F.H.</u> 22d. LOCATION (City, town, or county) <u>Cheswick, Allegheny, Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u> ADDRESS <u>Abingdon, Md.</u> | | 24a. REC'D BY REGISTRAR <u>May 18, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED
MAY 1964

5186

CERTIFICATE OF DEATH

05199

Reg. Dist. No. 702

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> | | | | c. LENGTH OF STAY IN 1b <u>6 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Birdenia</u> Middle <u>RIGDON</u> Last <u>RIGDON</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 5, 1869</u> | |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Mrs. Laura Walker, Fallston, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure (Pulmonary Edema)</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Cardio-Vascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>52</u> , to <u>April 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>56</u> , and that death occurred at <u>12:15 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>April 11, 1956</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. | | | | DATE SIGNED <u>April 11, 1956</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u> | | | | ADDRESS <u>Forest Hill, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>5-15-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>EMORY</u> | | 22d. LOCATION (City, town, or county) (State) <u>STREET, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-16-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Priscilla Lownd</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------|--|---------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED [Illegible] | | SEX [Illegible] | | AGE [Illegible] | |
| DATE OF DEATH [Illegible] | | PLACE OF DEATH [Illegible] | | TIME OF DEATH [Illegible] | |
| CAUSE OF DEATH [Illegible] | | MANNER OF DEATH [Illegible] | | PLACE OF BIRTH [Illegible] | |
| OCCUPATION [Illegible] | | MARITAL STATUS [Illegible] | | DATE OF BIRTH [Illegible] | |
| SIGNATURE OF DECEASED [Illegible] | | SIGNATURE OF WITNESS [Illegible] | | SIGNATURE OF PHYSICIAN [Illegible] | |
| SIGNATURE OF CLERK [Illegible] | | SIGNATURE OF REGISTRAR [Illegible] | | SIGNATURE OF JUDGE [Illegible] | |

RECEIVED
 MAY 18 1956
 BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05200

Reg. Dist. No. 182

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorlington</u> 78 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorlington</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William Workington Stine</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 24, 1877</u> 78 yrs. 9. AGE (In years last birthday) <u>78</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Blag</u> 11. BIRTHPLACE (State or foreign country) <u>Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 4. DATE OF DEATH <u>May 3</u> Month Day Year <u>19 56</u> 13. FATHER'S NAME <u>Theodore Stine</u> 14. MOTHER'S MAIDEN NAME <u>Mary Traver</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>217 09 148</u> 17. INFORMANT <u>Mrs W.W. Stine</u> Address <u>Dorlington, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide by hanging</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self in barn</u> 20c. TIME OF INJURY Month, Day, Year <u>5/3 56</u> Hour <u>4</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barn</u> 20f. (City or town) <u>Dorlington</u> (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Notural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5/3/56</u> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>May 6, 1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Dorlington Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Bailey</u> ADDRESS <u>Dorlington, Md.</u> 24a. REC'D BY REGISTRAR <u>May 11, 1956</u> 24b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 19 1964

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05201

5187

CERTIFICATE OF DEATH

Reg. Dist. No. 186

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre De Grace | | | | c. LENGTH OF STAY IN 1b 32 Yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 S. Adams St. | | | | d. STREET ADDRESS 119 S. Adams St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Ernest Middle Coulson Last Todd | | | | 4. DATE OF DEATH Month May Day 4 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 10, 1895 | 9. AGE (In years lost birthday) yrs. 60 | IF UNDER 1 YEAR Months 4 Days 4 Hours 1956 | IF UNDER 24 HRS. Hours 1956 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engine Man | | | | 10b. KIND OF BUSINESS OR INDUSTRY Rail Road | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME Robert W. Todd | | | | 14. MOTHER'S MAIDEN NAME Isabella Coulson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes 1st World | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Mrs Emily D. Todd | | | | Address Havre De Grace, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerotic + hypertensive heart disease DUE TO (c) 5 years INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. r. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from June 10, 1950 to May 4, 1956 , that I last saw the deceased alive on May 4 , 19 56 , and that death occurred at 12:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Havre de Grace, Maryland DATE SIGNED May 5, 1956 | | | | | | | |
| ACTUAL SIGNATURE Frank Wolbert MD | | | | M.D. Havre de Grace, Maryland | | | |
| PHYSICIAN'S NAME (Type) Frank Wolbert | | | | M.D. M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-7-1956 | | 22c. NAME OF CEMETERY OR CREMATORY West Nottingham | | 22d. LOCATION (City, town, or county) (State) Colora, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leea Patterson & Son | | | | ADDRESS Perryville, Md. | | 24a. REC'D BY REGISTRAR DATE May 7-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE A. L. Lewis M. D. | | | |

CERTIFICATE OF DEATH

| | | | |
|---|--|---------------------------------|--|
| DEPARTMENT OF HEALTH BALTIMORE, MARYLAND | | DATE OF DEATH _____ | |
| NAME OF DECEASED _____ | | SEX _____ | |
| AGE _____ | | RACE _____ | |
| PLACE OF BIRTH _____ | | PLACE OF DEATH _____ | |
| OCCUPATION _____ | | CAUSE OF DEATH _____ | |
| DATE OF BIRTH _____ | | TIME OF DEATH _____ | |
| SIGNATURE OF DECEASED _____ | | SIGNATURE OF WITNESS _____ | |
| SIGNATURE OF PHYSICIAN _____ | | SIGNATURE OF CORONER _____ | |
| SIGNATURE OF JURY _____ | | SIGNATURE OF JUDGE _____ | |
| SIGNATURE OF CLERK _____ | | SIGNATURE OF REGISTRAR _____ | |

BUREAU V. S.

MAY 8 1956

RECEIVED